DIVISION OF MEDICAL SERVICES
PROVIDER BULLETIN

Volume 27 Number 1 http://www.dss.mo.gov/dms September 14, 2004

PHYSICIAN BULLETIN
PROFESSIONAL/TECHNICAL GUIDELINES

CONTENTS

Missouri Medicaid is clarifying policy regarding professional and technical component modifiers to assist providers in claim submission and reduce billing errors.

PROFESSIONAL AND/OR TECHNICAL COMPONENT GUIDELINES (E.G. X-RAY/ NUCLEAR MEDICINE/EEG/EKG/LABORATORY/PATHOLOGY/ETC.)

Reference Medicare Services Newsletter, Indicators/Global Surgery Percentages/ Endoscopies at http://www.momedicare.com/provider/provnewslet/cptlogin.asp for professional and technical procedures. This website will bring you to the LICENSE FOR USE OF "Physicians' CURRENT PROCEDURAL TERMINOLOGY", FOURTH EDITION ("CPT") agreement which must be accepted before the Indicators/Global Surgery Percentages/ Endoscopies can be viewed. The professional/technical indicator assigned to each procedure code is found in Column PC-TC of the Indicator Table. (Note: Not all codes in the listing are covered by Missouri Medicaid; refer to the Missouri Medicaid fee schedule at http://dss.missouri.gov/dms/.)

The following guidelines should be used when billing Missouri Medicaid for procedures that have both professional and technical components:

Professional and Technical Component (Total Component-No Modifier)

- Can be billed by a physician, clinic, Federally Qualified Health Center (FQHC), independent radiologist, independent x-ray service or independent laboratory;
- Providers billing for laboratory procedures must have appropriate Clinical Laboratory Improvement Art (CLIA) certification;

- Must be billed on a professional claim;
- Diagnosis required on claim;
- Referring physician required **IF** billed by provider type 70 or 71 or providers with a specialty of radiology/radiation therapy;
- Should never be billed with inpatient, outpatient, or emergency room places of service (POS); and
- Can only be billed by the provider who does both technical and professional components.

Professional Component (Modifier 26)

- Can be billed by a physician, clinic, Federally Qualified Health Center (FQHC), independent radiologist, independent x-ray service independent laboratory or outpatient hospital (all department provider number);
- Providers billing for laboratory procedures must have appropriate CLIA certification;
- Must be billed on a professional claim;
- Diagnosis required on claim; and
- Referring physician required **IF** billed by provider type 70 or 71 or providers with a specialty of radiology/radiation therapy.

Technical Component (Modifier TC)

- Can be billed by a physician, clinic, Federally Qualified Health Center (FQHC), independent radiologist, independent x-ray service, independent laboratory or outpatient hospital;
- Providers billing for laboratory procedures must have appropriate CLIA certification;
- Must be billed on a professional claim for physician, clinic, radiologist, x-ray service or independent laboratory billing;
- Diagnosis required on claim;
- Referring physician required **IF** billed by provider type 70 or 71 or providers with a specialty of radiology/radiation therapy;
- Technical component may never be billed by the physician or clinic for services provided in an inpatient, outpatient or emergency room setting; and
- Hospitals must bill on the institutional claim for outpatient hospital billing.

BILLING CODES WHEN THE PC/TC MODIFIERS DO NOT APPLY

Some codes listed in Medicare's Indicators/Global Surgery Percentages/Endoscopies for professional/technical component modifiers have indicators that the concept of a professional/technical component do not apply. When procedure codes have these indicators, the codes should be billed **without** a modifier. Examples are procedure codes 78608 and 78609. For the complete listing of indicators refer to the PC/TC Indicator Table in the Medicare's Indicators/Global Surgery Percentages/Endoscopies at the above Medicare website.

CARDIAC CATHETERIZATION

When billing for cardiac catheterization services (procedure codes 93501, 93505 – 93533, and 93555 - 93572), the same guidelines for professional and technical components should be used.

Provider Bulletins are available on the DMS Website at http://www.dss.mo.gov/dms/pages/bulletins.htm. Bulletins will remain on the Published Bulletin site only until incorporated into the provider manuals as appropriate, then moved to the Archived Bulletin site.

Missouri Medicaid News: Providers and other interested parties are urged to go to the DMS Website at http://dss.missouri.gov/dms/subscribe/MedNewsSubscribe.htm to subscribe to the listserve to receive automatic notifications of provider bulletins, provider manual updates, and other official Missouri Medicaid communications via e-mail.

MC+ Managed Care: The information contained in this bulletin applies to coverage for:

- MC+ Fee-for-Service
- Medicaid Fee-for-Service
- Services not included in MC+ Managed Care

Questions regarding MC+ Managed Care benefits should be directed to the patient's MC+ Managed Care health plan. Before delivering a service, please check the patient's eligibility status by swiping the red MC+ card or by calling the Interactive Voice Response (IVR) System at 1-800-392-0938 and using Option One.

Provider Communications Hotline
800-392-0938 or 573-751-2896